

# **DELINEATION OF CLINICAL PRIVILEGES - PHYSICIAN ASSISTANT**

*(For use of this form, see AR 40-68; the proponent agency is OTSG.)*

|  |               |             |
|--|---------------|-------------|
| 1. NAME OF PROVIDER <i>(Last, First, MI)</i> | 2. RANK/GRADE | 3. FACILITY |
|--|---------------|-------------|

**INSTRUCTIONS:**

**PROVIDER:** Enter the appropriate provider code in the column marked "REQUESTED". Each category and/or individual privilege listed must be coded. For procedures listed, line through and initial any criteria/applications that do not apply. Your signature is required at the end of Section I. Once approved, any revisions or corrections to this list of privileges will require you to submit a new DA Form 5440.

**SUPERVISOR:** Review each category and/or individual privilege coded by the provider and enter the appropriate approval code in the column marked "APPROVED". This serves as your recommendation to the commander who is the approval authority. Your overall recommendation and signature are required in Section II of this form.

**GENERAL:** Physician Assistants will demonstrate skills in interviewing, examination, assessment, and management of patients with general medical, obstetrical, surgical, and psychiatric health problems. Seriously ill patients will be managed in consultation with or direct referral to appropriate medical specialists.

| PROVIDER CODES   | APPROVAL CODES   |
|--|--|
| 1 - Fully competent to perform                             | 1 - Approved as fully competent                        |
| 2 - Modification requested <i>(Justification attached)</i> | 2 - Modification required <i>(Justification noted)</i> |
| 3 - Supervision requested                                  | 3 - Supervision required                               |
| 4 - Not requested due to lack of expertise                 | 4 - Not approved, insufficient expertise               |
| 5 - Not requested due to lack of facility support          | 5 - Not approved, insufficient facility support        |

## **SECTION I - CLINICAL PRIVILEGES**

**Category I. Primary Care.**

Ambulatory care for soldiers, family members and other beneficiaries that involves uncomplicated illnesses or problems with low risk to patients. These duties will typically be performed in Troop Medical Clinics, Ambulatory Patient Care Clinics, or Outpatient Clinics.

| Requested | Approved |  |
|-----------|----------|--|
|           |          | Category I clinical privileges   |
|           |          | a. Diagnose and treat illnesses and injuries (all categories of beneficiaries) |
|           |          | b. Order and interpret laboratory tests  |
|           |          | c. Order and interpret radiographs (X-ray, CT, MRI and Ultrasound)             |
|           |          | d. Prescribe and/or administer P&T Committee approved medications              |
|           |          | e. Issue temporary profiles (not to exceed 30 days)                            |
|           |          | f. Perform complete histories and physicals (AR 40-501)                        |
|           |          | g. Supervision of immunizations (AR 40-562)                                    |
|           |          | h. Nuclear and Chemical Surety evaluations (AR 50-5 and 50-6)                  |
|           |          |  |
|           |          |  |

**Category II. Specialty Areas. Includes Category I.**

Requires residency or specialty training that prepares the physician assistant to perform duties, procedures or manage specific categories of patients.

| Requested | Approved |                                       | Requested | Approved |   |
|-----------|----------|---------------------------------------|-----------|----------|---|
|           |          | Category II clinical privileges       |           |          | f. Cardio-thoracic Surgery              |
|           |          | a. Aviation Medicine (Aeromedical PA) |           |          | g. Diving/Hyperbaric Medicine (DMO/HMO) |
|           |          | b. Orthopedics                        |           |          | h. Neurosurgery                         |
|           |          | c. Emergency Medicine                 |           |          | i. Dermatology                          |
|           |          | d. Occupational Medicine              |           |          |   |
|           |          | e. Cardiovascular Perfusion           |           |          |   |

**Category III. Procedures. Includes Categories I and II.**

| Requested | Approved |   | Requested | Approved |  |
|-----------|----------|---|-----------|----------|--|
|           |          | Category III clinical privileges        |           |          | e. Administration of IV fluids             |
|           |          | a. Joint aspiration/injection           |           |          | f. Nasogastric intubation                  |
|           |          | b. Wound care, debridement and suturing |           |          | g. Nasopharyngeal intubation               |
|           |          | c. Incision and drainage of abscesses   |           |          | h. Stabilization of fractures              |
|           |          | d. Urethral catheterization             |           |          | i. Reduction of simple extremity fractures |

| Category III. (Continued)  |          |   |           |          |   |
|--|----------|---|-----------|----------|---|
| Requested  | Approved |   | Requested | Approved |   |
|  |          | j. Administration of anesthesia                 |           |          | k. First assist in major surgical cases |
|  |          | (1) Digital                                     |           |          |   |
|  |          | (2) Local                                       |           |          |   |
|  |          | (3) Intercostal                                 |           |          |   |
| <b>Category IV. Inpatient Privileges.</b> Includes Categories I, II and III.<br>Typically requires specialty training or assignment to duties that necessitate these privileges. |          |   |           |          |   |
| Requested  | Approved |   | Requested | Approved |   |
|  |          | Category IV clinical privileges                 |           |          | d. *Narrative summaries                 |
|  |          | a. * Admission of patients                      |           |          | e. *Discharge patients                  |
|  |          | b. *Inpatient history and physical examinations |           |          |   |
|  |          | c. *Doctor's orders                             |           |          |   |
| *Requires physician review and signature within 24 hours.  |          |   |           |          |   |
| COMMENTS   |          |   |           |          |   |
|  |          | SIGNATURE OF PROVIDER                           |           |          | DATE (YYYYMMDD)                         |
| <b>SECTION II - SUPERVISOR'S RECOMMENDATION</b>  |          |   |           |          |   |
| Approval as requested <input type="checkbox"/> Approval with Modifications (Specify below) <input type="checkbox"/> Disapproval (Specify below) <input type="checkbox"/>         |          |   |           |          |   |
| COMMENTS   |          |   |           |          |   |
| DEPARTMENT/SERVICE CHIEF (Typed name and title)  |          | SIGNATURE                                       |           |          | DATE (YYYYMMDD)                         |
| <b>SECTION III - CREDENTIALS COMMITTEE RECOMMENDATION</b>  |          |   |           |          |   |
| Approval as requested <input type="checkbox"/> Approval with Modifications (Specify below) <input type="checkbox"/> Disapproval (Specify below) <input type="checkbox"/>         |          |   |           |          |   |
| COMMENTS   |          |   |           |          |   |
| CREDENTIALS COMMITTEE CHAIRPERSON (Name and rank)  |          | SIGNATURE                                       |           |          | DATE (YYYYMMDD)                         |

# EVALUATION OF CLINICAL PRIVILEGES - PHYSICIAN ASSISTANT

(For use of this form, see AR 40-68; the proponent agency is OTSG.)

|  |  |  |
|--|--|--|
| 1. NAME OF PROVIDER <i>(Last, First, MI)</i> | 2. RANK/GRADE  | 3. PERIOD OF EVALUATION <i>(YYYYMMDD)</i><br>FROM _____ TO _____ |
| 4. DEPARTMENT/SERVICE                        | 5. FACILITY <i>(Name and Address: City/State/ZIP Code)</i> |  |

INSTRUCTIONS: Evaluation of clinical privileges is based on the provider's demonstrated patient management abilities appropriate to this discipline, and his/her competence to perform the various technical skills and procedures indicated below. All privileges applicable to this provider will be evaluated. For procedures listed, line through and initial any criteria/applications that do not apply. The privilege approval code (see corresponding DA Form 5440) will be entered in the left column titled "CODE" for each category or individual privilege. Those with an approval code of "4" or "5" will be marked "Not Applicable". Any rating that is "Unacceptable" must be explained in SECTION II - "COMMENTS". Comments on this evaluation must be taken into consideration as part of the provider's reappraisal/renewal of clinical privileges and appointment/reappointment to the medical staff.

## SECTION I - DEPARTMENT/SERVICE CHIEF EVALUATION

| CODE | PRIVILEGE CATEGORY   | ACCEPTABLE | UN-ACCEPTABLE | NOT APPLICABLE |
|------|--|------------|---------------|----------------|
|      | Category I clinical privileges   |            |               |                |
|      | a. Diagnose and treat illnesses and injuries (all categories of beneficiaries) |            |               |                |
|      | b. Order and interpret laboratory tests  |            |               |                |
|      | c. Order and interpret radiographs (X-ray, CT, MRI and Ultrasound)             |            |               |                |
|      | d. Prescribe and/or administer P&T Committee approved medications              |            |               |                |
|      | e. Issue temporary profiles (not to exceed 30 days)                            |            |               |                |
|      | f. Perform complete histories and physicals (AR 40-501)                        |            |               |                |
|      | g. Supervision of immunizations (AR 40-562)                                    |            |               |                |
|      | h. Nuclear and Chemical Surety evaluations (AR 50-5 and 50-6)                  |            |               |                |
|      |  |            |               |                |
|      |  |            |               |                |
|      | Category II clinical privileges  |            |               |                |
|      | a. Aviation Medicine (Aeromedical PA)  |            |               |                |
|      | b. Orthopedics   |            |               |                |
|      | c. Emergency Medicine  |            |               |                |
|      | d. Occupational Medicine   |            |               |                |
|      | e. Cardiovascular Perfusion  |            |               |                |
|      | f. Cardio-thoracic Surgery   |            |               |                |
|      | g. Diving/Hyperbaric Medicine (DMO/HMO)  |            |               |                |
|      | h. Neurosurgery  |            |               |                |
|      | i. Dermatology   |            |               |                |
|      |  |            |               |                |
|      |  |            |               |                |
|      | Category III clinical privileges   |            |               |                |
|      | a. Joint aspiration/injection  |            |               |                |
|      | b. Wound care, debridement and suturing  |            |               |                |
|      | c. Incision and drainage of abscesses  |            |               |                |
|      | d. Urethral catheterization  |            |               |                |
|      | e. Administration of IV fluids   |            |               |                |
|      | f. Nasogastric intubation  |            |               |                |
|      | g. Nasopharyngeal intubation   |            |               |                |
|      | h. Stabilization of fractures  |            |               |                |
|      | i. Reduction of simple extremity fractures                                     |            |               |                |
|      | j. Administration of anesthesia  |            |               |                |
|      | (1) Digital  |            |               |                |
|      | (2) Local  |            |               |                |

| CODE | PRIVILEGE CATEGORY <i>(Continued)</i>           | ACCEPTABLE | UN-ACCEPTABLE | NOT APPLICABLE |
|------|---|------------|---------------|----------------|
|      | (3) Intercostal                                 |            |               |                |
|      | k. First assist in major surgical cases         |            |               |                |
|      |   |            |               |                |
|      |   |            |               |                |
|      |   |            |               |                |
|      | Category IV clinical privileges                 |            |               |                |
|      | a. *Admission of patients                       |            |               |                |
|      | b. *Inpatient history and physical examinations |            |               |                |
|      | c. *Doctor's orders                             |            |               |                |
|      | d. *Narrative summaries                         |            |               |                |
|      | e. *Discharge patients                          |            |               |                |
|      |   |            |               |                |
|      |   |            |               |                |
|      |   |            |               |                |

\*Requires physician review and signature within 24 hours.

**SECTION II - COMMENTS** *(Explain any rating that is "Unacceptable".)*

NAME AND TITLE OF EVALUATOR

SIGNATURE

DATE (YYYYMMDD)